VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

May 7, 2014

Ms. Patricia Horn, Administrator
Victorian House Residence At Cedar Hill
49 Cedar Hill Drive
Windsor, VT 05089

Dear Ms. Horn:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 8, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0293	A. BUILDING: ______ B. WING ______	C 04/08/2014

RECEIVED Division of Licensing and Protection MAY - 5 14

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN HOUSE RESIDENCE AT CEDAR HI	49 CEDAR HILL DRIVE WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey and investigation of three entity reports was completed by the Division of Licensing and Protection from 4/7/14 through 4/8/14. There was a regulatory violation cited related to one of the entity reports.	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that 1 of 5 residents in the applicable sample (Resident #5) was promptly assessed at a point in which there was a change in the resident's physical condition. Findings include: Per review of the medical record and the report of an internal investigation, Resident #5 fell at approximately 5:45 AM on 12/21/12. Resident Assistant A was present in the adjoining bathroom, but out of reach as Resident #5 fell while proceeding toward the bed with a walker. Resident Assistant A checked the movement of extremities and took vital signs, and assisted Resident #5 into bed. Resident Assistant A did not call a nurse to evaluate the resident. Later that morning, at approximately 9:00 AM, Resident	R136	**Resident Care and Home Services** 5.7c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. The Victorian House Nurse Manager and the RN Oversight initiated the investigation with Resident#5 on 11/21/12. When they completed their investigation, they educated the staff member in question on the importance of notifying the Nurse Manager, RN Oversight or On Call Nurse promptly of a resident change in condition that needed a licensed nurse's assessment. On 4/24/2014, the Victorian House Nurse Manager met with the facility Staff. She conducted an in-service on the importance of notifying the Nurse promptly if there is a change in resident's condition and what those changes in condition could be. The Victorian House at Cedar Hill has implemented a new policy for Resident Assistants regarding Nurse Notification. All current Resident Attendants that work for the Victorian House will be educated on and sign off on this policy by 6/1/14. (See below for Nurse Notification Policy.) The Victorian House also has a new section in its Medication Course detailing when RAs should notify the nurse manager or on call nurse.	

Division of Licensing and Protection

POC accept J. Hasner / F Keen RN MSN DAA 5/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Horn — TITLE: Community Administrator — (X6) DATE: 5/2/14

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R136	Continued From page 1 Assistant B woke Resident #5 for breakfast and found him/her to verbalize, "it hurts so much I don't think I can get up". Resident Assistant B called for a nurse at that time. During an interview on 4/7/14 at 2:45 PM, the Director of Nursing Services (DNS) [who is a Registered Nurse] confirmed per documentation of the incident that s/he assessed Resident #5 at approximately 9:00 AM on 12/21/12 and found the left leg to be externally rotated and shortened. Resident #5 was transported to hospital and found to have a fractured hip. The DNS further confirmed that the policy of the facility and the expectation dictated that Resident Assistant A would call the on-call nurse to assess the resident after a fall. Additionally, the written report of the incident, dated 12/31/12 and signed by the Administrator, states, "It is our policy that after a fall in Victorian House Level III the RA should call the nurse to evaluate".	R136	The Nurse Manager of the Victorian House will routinely review resident records to insure that he/she is aware of current resident conditions and these changes in conditions are being documented and staff is notifying nurse management timely. If a Resident Assistant is found to breach this policy the staff member in question will be educated and progressively disciplined up to and including termination. In addition, Victorian House will hold a staff meeting with all Resident Assistants to discuss and re-educate. Date of Completion 6/1/2014 **Victorian House at Cedar Hill *Nurse Notification Policy*** It is the policy of The Victorian House at Cedar Hill that Resident Attendants will notify the Nurse Manager, Director of Nurses or on call nurse promptly in the following situations: • Resident Falls • New Resident bruise or skin tear. • Resident is experiencing a new behavior. • Resident wanders without purpose outside the facility • Resident Attendant questions a physician order • Resident Attendant notices a mental or physical change from the resident baseline. • Resident Attendant questions a treatment or other nursing procedure or has any question or concern regarding nursing care or medication management. This notification ensures that a licensed nurse is given the opportunity to assess the resident and notify the primary care physician to consult changes in status and care regimen. The Resident Attendant must write a note to document the situation, the call to the nurse and the nurse's response to the Resident Attendant. The Nurse will also document needed follow through once they are on site.	